EXHIBIT 10

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PRESCRIPTION DRUG PRICES: ARE WE GETTING OUR MONEY'S WORTH?

A MAJORITY STAFF REPORT

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

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This document has been printed for information purposes. It does not offer findings or recommendations by this committee.

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FOREWORD

On July 11, 1989, Congress learned that the Congressional Budget Office (CBO) would soon significantly raise its cost estimate for the new Medicare Catastrophic Coverage Act (MCCA) prescription drug benefit. As a result, many observers now believe that the Congress will not be able to lower premiums for the benefits included in the Act. Moreover, because of the CBO estimate, some Members of Congress have advocated delaying or eliminating the Medicare outpatient drug benefit.

The prescription drug benefit included in the MCCA is viewed by many to be its most important provision, soon to help 9 million older Americans annually to pay drug bills. Prescription drug costs represent the largest out-of-pocket health care expense for three of every four older Americans. It is therefore not surprising that over 15 percent of the elderly patients who require prescriptions report they are unable to pay for their medications.

In light of this cost burden, proposals to reduce insurance protection against the cost of prescription drugs greatly concern older Americans and their advocates. Furthermore, during the last decade, health policymakers of both political parties have concluded that it is both more constructive and compassionate to attempt to address the reasons behind rapidly increasing health care costs than to simply deny benefits to those in need.

The Special Committee on Aging hearing of July 18, together with this staff information paper, represent an attempt to target the reasons behind prescription drug cost increases. This staff report summarizes the findings of the Committee's investigation into prescription drug costs, drug price differentials in domestic and international markets, the relative value of products resulting from drug research and development, and the prices the Medicare program will be paying for its new coverage of prescription drugs.

It is my hope that this information will help interested parties better understand the prescription drug industry and the difficulties of controlling prescription drug price increases. As is the case in most detailed inquiries into a subject, the information that has been gathered leads us to ask additional questions. I intend to hold additional hearings on this subject to help the Congress evaluate options for efficiently providing the oldest and poorest Americans with protection from the high cost of prescription drugs.

David Pryor
Chairman, United States Senate
Special Committee on Aging

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- In 1987 The Economist noted that "slowing down in volume growth in existing markets would not be so important if there were dozens of exciting new drugs in new therapeutic areas coming on to the market in the next year or so; but there are not. Most recent product launches have been me-toos, which do not find new markets but simply provide substitutes for older products...Drug companies have therefore been forced to rely on price increases on older products to boost their profits."

- Drug manufacturers have been rewarded with high profits for relying on price increases during a period of stagnant innovation. Investment analysts Hambrecht and Quist, Inc. stated in 1988 that "return on equity for the pharmaceutical industry has been consistently above that of the [Standard and Poors] 400, the main industrial sector of the market. If anything, this gap has widened over the past ten years..."

Finding 6: Citizens of most countries of the world pay less than U.S. consumers for their prescription drugs.

- An analysis of prescription drug prices in seven European countries, published in 1988 by the Farmindustria, the Italian pharmaceutical manufacturers association, shows that U.S. consumers pay up to 5 times what European citizens pay for brand name drugs. (See Chart, Appendix F.)

  Only the citizens of Japan pay higher prices for prescription drugs than Americans. However, unlike the federal and State governments in the United States, the Japanese government has slashed drug prices by an average of 50% over the past five years in response to this problem.

Finding 7: There are two markets in the United States for most big-selling prescription drugs: a price-competitive market characterized by deep discounts off the published list price, and a high-priced market, where retail customers, Medicare and Medicaid purchase their prescription drugs.

- Manufacturers have in the past sought to justify high prices for patented drugs with the assertion that R&D costs must be recouped before the drug's patent expires, subjecting it to price competition from generic drugs.

  However, rather than engaging in price competition, manufacturers typically continue to raise brand name drug prices even after a patent expires, seemingly without regard to one or more generic drugs entering the market as "competitors" (see Appendix G).

  Manufacturers appear to find it necessary to compete with generics on the basis of price only where a buyer has insisted on obtaining better prices, and has organized its purchasing process to include competitive bidding and/or negotiating prices with manufacturers.

- The Department of Veterans' Affairs (DVA, formerly the Veterans Administration) has an extremely successful program in which it negotiates prices with manufacturers of single source drugs and puts multiple source drugs out to bid to several manufacturers (see Appendices H and I).

  DVA achieves an average discount of 41% off the manufacturer's published "Average Wholesale Price" (AWP) for single source drugs (those still under patent), and an average of 67% off the published AWP for multiple source drugs.

  According to DVA, these savings are obtained by DVA through its Federal Supply Schedule (FSS) procurement scheme, in which the drug manufacturer remains responsible for delivering the product "through commerical distribution channels" to DVA's hospitals and outpatient pharmacies.

  Much deeper discounts are achieved by DVA in its Depot system, in which DVA itself is responsible for warehousing, storage, and distribution of the drug products it purchases in large quantities.

- The State of Kansas Medicaid program embarked on a program similar to DVA's three years ago, saving a few hundred thousand dollars per year, but manufacturers' refusal to bid or negotiate has cost the State millions of dollars.

  Kansas Medicaid administrators estimate the State's taxpayers could save up to an additional $500,000/year if manufacturers of the four currently marketed anti-ulcer drugs known as "H2 antagonists" would respond to offers with bids.

  Kansas officials believe State and federal governments could save hundreds of millions of dollars if Congress were to put into place a national bidding and negotiating program under the Medicaid program.

- Hospitals, Health Maintenance Organizations, and nursing homes that contract with wholesalers to purchase prescription drugs from a predetermined list are able to achieve discounts of up to 99% off the manufacturer's published "Average Wholesale Price" (AWP), even for brand name products (see Appendices H and I).